COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES

NEED FOR IEP REVIEW

TO: _____DATE:_____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____
_____
_____
_____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments_____
_____
_____
_____

cc: Chart